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Proposed Regulation
Agency Background Document

Agency name	Boards of Nursing and Medicine, Department of Health Professions
Virginia Administrative Code (VAC) citation(s)	18VAC90-30 18VAC90-40
Regulation title(s)	Regulations Governing the Licensure of Nurse Practitioners Regulations Governing Prescriptive Authority for Nurse Practitioners
Action title	Autonomous practice
Date this document prepared	3/20/19

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Order 14 (as amended, July 16, 2018), the Regulations for Filing and Publishing Agency Regulations (1 VAC7-10), and the *Virginia Register Form, Style, and Procedure Manual for Publication of Virginia Regulations.*

Brief Summary

Please provide a brief summary (preferably no more than 2 or 3 paragraphs) of this regulatory change (i.e., new regulation, amendments to an existing regulation, or repeal of an existing regulation). Alert the reader to all substantive matters. If applicable, generally describe the existing regulation.

Regulations set the qualifications for authorization for a nurse practitioner to practice without a practice agreement with a patient care team physician, including the hours required for the equivalent of five years of full-time clinical experience, content of the attestation from the physician and nurse practitioner, submission of an attestation when the nurse practitioner is unable to obtain a physician attestation, requirements for autonomous practice, and the fee for authorization.

The goal of the Boards was to adhere as closely as possible to the statutory language relating to autonomous practice and to adopt regulations that were reasonable and clearly written.

Acronyms and Definitions

Please define all acronyms used in the Agency Background Document. Also, please define any technical terms that are used in the document that are not also defined in the "Definition" section of the regulations.

N/A

Mandate and Impetus

Please identify the mandate for this regulatory change, and any other impetus that specifically prompted its initiation (e.g., new or modified mandate, petition for rulemaking, periodic review, board decision, etc.). For purposes of executive branch review, "mandate" has the same meaning as defined in Executive Order 14 (as amended, July 16, 2018), "a directive from the General Assembly, the federal government, or a court that requires that a regulation be promulgated, amended, or repealed in whole or part."

The Boards of Medicine and Nursing have adopted regulations for autonomous practice of nurse practitioners in compliance with the second enactment of HB793 of the 2018 General Assembly, which specified:
That the Boards of Medicine and Nursing shall jointly promulgate regulations to implement the provisions of this act, which shall govern the practice of nurse practitioners practicing without a practice agreement in accordance with the provisions of this act, to be effective within 280 days of its enactment.

Regulations proposed by the Boards are identical to emergency regulations in effect.

Legal Basis

Please identify (1) the agency or other promulgating entity, and (2) the state and/or federal legal authority for the regulatory change, including the most relevant citations to the Code of Virginia or Acts of Assembly chapter number(s), if applicable. Your citation must include a specific provision, if any, authorizing the promulgating entity to regulate this specific subject or program, as well as a reference to the agency or promulgating entity's overall regulatory authority.

Regulations are promulgated under the general authority of Chapter 24 of Title 54.1 of the Code of Virginia. Section 54.1-2400, which provides the Boards of Medicine and Nursing the authority to promulgate regulations to administer the regulatory system:

> ***§ 54.1-2400 -General powers and duties of health regulatory boards***
> *The general powers and duties of health regulatory boards shall be:*
>
> *1. To establish the qualifications for registration, certification or licensure in accordance with the applicable law which are necessary to ensure competence and integrity to engage in the regulated professions. ...*

6. To promulgate regulations in accordance with the Administrative Process Act (§ 9-6.14:1 et seq.) which are reasonable and necessary to administer effectively the regulatory system. Such regulations shall not conflict with the purposes and intent of this chapter or of Chapter 1 (§ 54.1-100 et seq.) and Chapter 25 (§ 54.1-2500 et seq.) of this title. ...

Specific statutory authority for licensure and practice of nurse practitioners and for prescriptive authority is found in Chapter 29 of Title 54.1 as amended in 2018 for autonomous practice and as follows:

§ 54.1-2957. Licensure and practice of nurse practitioners; practice agreements.
A. As used in this section:
"Clinical experience" means the postgraduate delivery of health care directly to patients pursuant to a practice agreement with a patient care team physician.
"Collaboration" means the communication and decision-making process among a nurse practitioner, patient care team physician, and other health care providers who are members of a patient care team related to the treatment that includes the degree of cooperation necessary to provide treatment and care of a patient and includes (i) communication of data and information about the treatment and care of a patient, including exchange of clinical observations and assessments, and (ii) development of an appropriate plan of care, including decisions regarding the health care provided, accessing and assessment of appropriate additional resources or expertise, and arrangement of appropriate referrals, testing, or studies.

"Consultation" means the communicating of data and information, exchanging of clinical observations and assessments, accessing and assessing of additional resources and expertise, problem-solving, and arranging for referrals, testing, or studies.

B. The Board of Medicine and the Board of Nursing shall jointly prescribe the regulations governing the licensure of nurse practitioners. It is unlawful for a person to practice as a nurse practitioner in the Commonwealth unless he holds such a joint license.

C. Every nurse practitioner other than a nurse practitioner licensed by the Boards of Medicine and Nursing as a certified nurse midwife or a certified registered nurse anesthetist or a nurse practitioner who meets the requirements of subsection I shall maintain appropriate collaboration and consultation, as evidenced in a written or electronic practice agreement, with at least one patient care team physician. A nurse practitioner who meets the requirements of subsection I may practice without a written or electronic practice agreement. A nurse practitioner who is licensed by the Boards of Medicine and Nursing as a certified nurse midwife shall practice pursuant to subsection H. A nurse practitioner who is a certified registered nurse anesthetists shall practice under the supervision of a licensed doctor of medicine, osteopathy, podiatry, or dentistry. A nurse practitioner who is appointed as a medical examiner pursuant to § 32.1-282 shall practice in collaboration with a licensed doctor of medicine or osteopathic medicine who has been appointed to serve as a medical examiner pursuant to § 32.1-282. Collaboration and consultation among nurse practitioners and patient care team physicians may be provided through telemedicine as described in § 38.2-3418.16.

Physicians on patient care teams may require that a nurse practitioner be covered by a professional liability insurance policy with limits equal to the current limitation on damages set forth in § 8.01-581.15.

Service on a patient care team by a patient care team member shall not, by the existence of such service alone, establish or create liability for the actions or inactions of other team members.

D. The Boards of Medicine and Nursing shall jointly promulgate regulations specifying collaboration and consultation among physicians and nurse practitioners working as part of patient care teams that shall include the development of, and periodic review and revision of, a written or electronic practice agreement; guidelines for availability and ongoing communications that define consultation among the collaborating parties and the patient; and periodic joint evaluation of the services delivered. Practice agreements shall include provisions for (i) periodic review of health records, which may include visits to the site where health care is delivered, in the manner and at the frequency determined by the nurse practitioner and the patient care team physician and (ii) input from appropriate health care providers in complex clinical cases and patient emergencies and for referrals. Evidence of a practice agreement shall be maintained by a nurse practitioner and provided to the Boards upon request. For nurse practitioners providing care to patients within a hospital or health care system, the practice agreement may be included as part of documents delineating the nurse practitioner's clinical privileges or the electronic or written delineation of duties and responsibilities in collaboration and consultation with a patient care team physician.

E. The Boards of Medicine and Nursing may issue a license by endorsement to an applicant to practice as a nurse practitioner if the applicant has been licensed as a nurse practitioner under the laws of another state and, pursuant to regulations of the Boards, the applicant meets the qualifications for licensure required of nurse practitioners in the Commonwealth. A nurse practitioner to whom a license is issued by endorsement may practice without a practice agreement with a patient care team physician pursuant to subsection I if such application provides an attestation to the Boards that the applicant has completed the equivalent of at least five years of full-time clinical experience, as determined by the Boards, in accordance with the laws of the state in which the nurse practitioner was licensed.

F. Pending the outcome of the next National Specialty Examination, the Boards may jointly grant temporary licensure to nurse practitioners.

G. In the event a physician who is serving as a patient care team physician dies, becomes disabled, retires from active practice, surrenders his license or has it suspended or revoked by the Board, or relocates his practice such that he is no longer able to serve, and a nurse practitioner is unable to enter into a new practice agreement with another patient care team physician, the nurse practitioner may continue to practice upon notification to the designee or his alternate of the Boards and receipt of such notification. Such nurse practitioner may continue to treat patients without a patient care team physician for an initial period not to exceed 60 days, provided the nurse practitioner continues to prescribe only those drugs previously authorized by the practice agreement with such physician and to have access to appropriate input from appropriate health care providers in complex clinical cases and patient emergencies and for

referrals. The designee or his alternate of the Boards shall grant permission for the nurse practitioner to continue practice under this subsection for another 60 days, provided the nurse practitioner provides evidence of efforts made to secure another patient care team physician and of access to physician input.

H. Nurse practitioners licensed by the Boards of Medicine and Nursing in the category of certified nurse midwife shall practice in consultation with a licensed physician in accordance with a practice agreement between the nurse practitioner and the licensed physician. Such practice agreement shall address the availability of the physician for routine and urgent consultation on patient care. Evidence of a practice agreement shall be maintained by a nurse practitioner and provided to the Boards upon request. The Boards shall jointly promulgate regulations, consistent with the Standards for the Practice of Midwifery set by the American College of Nurse-Midwives, governing such practice.

I. A nurse practitioner, other than a nurse practitioner licensed by the Boards of Medicine and Nursing in the category of certified nurse midwife or certified registered nurse anesthetist, who has completed the equivalent of at least five years of full-time clinical experience as a licensed nurse practitioner, as determined by the Boards, may practice in the practice category in which he is certified and licensed without a written or electronic practice agreement upon receipt by the nurse practitioner of an attestation from the patient care team physician stating (i) that the patient care team physician has served as a patient care team physician on a patient care team with the nurse practitioner pursuant to a practice agreement meeting the requirements of this section and § 54.1-2957.01; (ii) that while a party to such practice agreement, the patient care team physician routinely practiced with a patient population and in a practice area included within the category for which the nurse practitioner was certified and licensed; and (iii) the period of time for which the patient care team physician practiced with the nurse practitioner under such a practice agreement. A copy of such attestation shall be submitted to the Boards together with a fee established by the Boards. Upon receipt of such attestation and verification that a nurse practitioner satisfies the requirements of this subsection, the Boards shall issue to the nurse practitioner a new license that includes a designation indicating that the nurse practitioner is authorized to practice without a practice agreement. In the event that a nurse practitioner is unable to obtain the attestation required by this subsection, the Boards may accept other evidence demonstrating that the applicant has met the requirements of this subsection in accordance with regulations adopted by the Boards.

A nurse practitioner authorized to practice without a practice agreement pursuant to this subsection shall (a) only practice within the scope of his clinical and professional training and limits of his knowledge and experience and consistent with the applicable standards of care, (b) consult and collaborate with other health care providers based on the clinical conditions of the patient to whom health care is provided, and (c) establish a plan for referral of complex medical cases and emergencies to physicians or other appropriate health care providers.

A nurse practitioner practicing without a practice agreement pursuant to this subsection shall obtain and maintain coverage by or shall be named insured on a professional liability insurance policy with limits equal to the current limitation on damages set forth in § 8.01-581.15.

§ 54.1-2957.01. Prescription of certain controlled substances and devices by licensed nurse practitioners.

A. In accordance with the provisions of this section and pursuant to the requirements of Chapter 33 (§ 54.1-3300 et seq.), a licensed nurse practitioner, other than a certified registered nurse anesthetist, shall have the authority to prescribe Schedule II through Schedule VI controlled substances and devices as set forth in Chapter 34 (§ 54.1-3400 et seq.).

B. A nurse practitioner who does not meet the requirements for practice without a written or electronic practice agreement set forth in subsection I of § 54.1-2957 shall prescribe controlled substances or devices only if such prescribing is authorized by a written or electronic practice agreement entered into by the nurse practitioner and a patient care team physician. Such nurse practitioner shall provide to the Boards of Medicine and Nursing such evidence as the Boards may jointly require that the nurse practitioner has entered into and is, at the time of writing a prescription, a party to a written or electronic practice agreement with a patient care team physician that clearly states the prescriptive practices of the nurse practitioner. Such written or electronic practice agreements shall include the controlled substances the nurse practitioner is or is not authorized to prescribe and may restrict such prescriptive authority as described in the practice agreement. Evidence of a practice agreement shall be maintained by a nurse practitioner pursuant to § 54.1-2957. Practice agreements authorizing a nurse practitioner to prescribe controlled substances or devices pursuant to this section either shall be signed by the patient care team physician or shall clearly state the name of the patient care team physician who has entered into the practice agreement with the nurse practitioner.

It shall be unlawful for a nurse practitioner to prescribe controlled substances or devices pursuant to this section unless (i) such prescription is authorized by the written or electronic practice agreement or (ii) the nurse practitioner is authorized to practice without a written or electronic practice agreement pursuant to subsection I of § 54.1-2957.

C. The Boards of Medicine and Nursing shall promulgate regulations governing the prescriptive authority of nurse practitioners as are deemed reasonable and necessary to ensure an appropriate standard of care for patients. Such regulations shall include requirements as may be necessary to ensure continued nurse practitioner competency, which may include continuing education, testing, or any other requirement, and shall address the need to promote ethical practice, an appropriate standard of care, patient safety, the use of new pharmaceuticals, and appropriate communication with patients.

D. This section shall not limit the functions and procedures of certified registered nurse anesthetists or of any nurse practitioners which are otherwise authorized by law or regulation.

E. The following restrictions shall apply to any nurse practitioner authorized to prescribe drugs and devices pursuant to this section:

1. The nurse practitioner shall disclose to the patient at the initial encounter that he is a licensed nurse practitioner. Any party to a practice agreement shall disclose, upon request of a patient or his legal representative, the name of the patient care team physician and information regarding how to contact the patient care team physician.

2. Physicians shall not serve as a patient care team physician on a patient care team at any one time to more than six nurse practitioners.

F. This section shall not prohibit a licensed nurse practitioner from administering controlled substances in compliance with the definition of "administer" in § 54.1-3401 or from receiving and dispensing manufacturers' professional samples of controlled substances in compliance with the provisions of this section.

G. Notwithstanding any provision of law or regulation to the contrary, a nurse practitioner licensed by the Boards of Medicine and Nursing in the category of certified nurse midwife and holding a license for prescriptive authority may prescribe (i) Schedules II through V controlled substances in accordance with any prescriptive authority included in a practice agreement with a licensed physician pursuant to subsection H of § 54.1-2957 and (ii) Schedule VI controlled substances without the requirement for inclusion of such prescriptive authority in a practice agreement.

Purpose

Please explain the need for the regulatory change, including a description of: (1) the rationale or justification, (2) the specific reasons the regulatory change is essential to protect the health, safety or welfare of citizens, and (3) the goals of the regulatory change and the problems it's intended to solve.

Regulations for autonomous practice are consistent with the statute as amended by the 2018 General Assembly and provide for evidence of years of clinical practice with a patient care team physician and for the limitation of practice within the category for which a nurse practitioner is licensed and certified. By law and regulation, a nurse practitioner practicing autonomously must "*(a) only practice within the scope of his clinical and professional training and limits of his knowledge and experience and consistent with the applicable standards of care, (b) consult and collaborate with other health care providers based on the clinical conditions of the patient to whom health care is provided, and (c) establish a plan for referral of complex medical cases and emergencies to physicians or other appropriate health care providers."* Therefore, the health and safety of patients is adequately protected by the qualifications for autonomous practice and the specified scope of such practice.

Substance

Please briefly identify and explain the new substantive provisions, the substantive changes to existing sections, or both. A more detailed discussion is provided in the "Detail of Changes" section below.

Regulations set the qualifications for authorization for a nurse practitioner to practice without a practice agreement with a patient care team physician, including the hours required for the equivalent of five years of full-time clinical experience, content of the attestation from the physician and nurse practitioner, submission of an attestation when the nurse practitioner is unable to obtain a physician attestation, requirements for autonomous practice, and the fee for authorization.

Issues

Please identify the issues associated with the regulatory change, including: 1) the primary advantages and disadvantages to the public, such as individual private citizens or businesses, of implementing the new or amended provisions; 2) the primary advantages and disadvantages to the agency or the Commonwealth; and 3) other pertinent matters of interest to the regulated community, government officials, and the public. If there are no disadvantages to the public or the Commonwealth, include a specific statement to that effect.

1) The primary advantage to the public is the potential for an expansion of access to care. By allowing nurse practitioners to practice autonomously, it is anticipated that there will be an increased number who will choose to open practices in underserved areas where it is currently difficult to find a collaborating physician. The agency does not believe there are disadvantages to the public because nurse practitioners practicing autonomously are still required to consult and collaborate with other health care providers based on clinical conditions and to only practice within the scope of their training and limits of experience.
2) There are no particular advantages or disadvantages to the agency; there may be an advantage to the Commonwealth by an increase in access to care.
3) Other matters interest revolve around the implementation and application of statutory and regulatory provisions. The medical community remains concerned that more detail is needed about the alignment of specialty areas of practice and the patient population for an attestation of hours of clinical experience. The nurse practitioner community remains concerned about the number of years one must practice before he/she is eligible for autonomous practice.

   The General Assembly is interested in the impact of autonomous practice and has included a fourth enactment in the legislation requiring: *That the Boards of Medicine and Nursing shall report on data on the implementation of this act, including the number of nurse practitioners who have been authorized to practice without a practice agreement, the geographic and specialty areas in which nurse practitioners are practicing without a practice agreement, and any complaints or disciplinary actions taken against such nurse practitioners, along with any recommended modifications to the requirements of this act including any modifications to the clinical experience requirements for practicing without a practice agreement, to the Chairmen of the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health and the Chairman of the Joint Commission on Health Care by November 1, 2021.*

   The Director of the Department of Health Professions has reviewed the proposal and performed a competitive impact analysis. The Board is authorized under § 54.1-2400 to "*To promulgate regulations in accordance with the Administrative Process Act (§ 2.2-4000 et seq.) which are reasonable and necessary to administer effectively the regulatory system. Such regulations shall not conflict with the purposes and intent of this chapter or of Chapter 1 (§ 54.1-100 et seq.) and Chapter 25 (§ 54.1-2500 et seq.) of this title.*" Any restraint on competition as a result of promulgating this regulation is a foreseeable result of the statute requiring years of practice with a patient care team physician in order to protect the safety and health of clients/patients in the Commonwealth.

Requirements More Restrictive than Federal

Please identify and describe any requirement of the regulatory change which is more restrictive than applicable federal requirements. Include a specific citation for each applicable federal requirement, and a rationale for the need for the more restrictive requirements. If there are no applicable federal requirements, or no requirements that exceed applicable federal requirements, include a specific statement to that effect.

There are no applicable federal requirements.

Agencies, Localities, and Other Entities Particularly Affected

Please identify any other state agencies, localities, or other entities particularly affected by the regulatory change. "Particularly affected" are those that are likely to bear any identified disproportionate material impact which would not be experienced by other agencies, localities, or entities. "Locality" can refer to either local governments or the locations in the Commonwealth where the activities relevant to the regulation or regulatory change are most likely to occur. If no agency, locality, or entity is particularly affected, include a specific statement to that effect.

Other State Agencies Particularly Affected – To the extent other state agencies, such as the Department of Health, employ nurse practitioners who qualify for autonomous practice, they may benefit from the ability of the NP to practice without a practice agreement with a physician.

Localities Particularly Affected – No direct impact, but NPs who can practice independently may be able to serve smaller communities in parts of the state where health care services are more remote or limited.

Other Entities Particularly Affected – No impact

Economic Impact

Pursuant to § 2.2-4007.04 of the Code of Virginia, please identify all specific economic impacts (costs and/or benefits), anticipated to result from the regulatory change. When describing a particular economic impact, specify which new requirement or change in requirement creates the anticipated economic impact. Please keep in mind that this is change versus the status quo.

Impact on State Agencies

For your agency: projected costs, savings, fees or revenues resulting from the regulatory change, including: a) fund source / fund detail; b) delineation of one-time versus on-going expenditures; and c) whether any costs or revenue loss can be absorbed within existing resources	As a special fund agency, the Board must generate sufficient revenue to cover its expenditures from non-general funds, specifically the application fees it charges to practitioners or entities for necessary functions of regulation. All notifications will be done electronically. See explanation of application fee of $100 in Detail of Changes, Chapter 30, Section 50.

For other state agencies: projected costs, savings, fees or revenues resulting from the regulatory change, including a delineation of one-time versus on-going expenditures.	There are no costs to other agencies.
For all agencies: Benefits the regulatory change is designed to produce.	There is no specified benefit from the regulatory change.

Impact on Localities

Projected costs, savings, fees or revenues resulting from the regulatory change.	There are no costs, savings, etc. to localities.
Benefits the regulatory change is designed to produce.	Without the costs of securing a patient care team physician to oversee their practice, there may be a slight increase in nurse practitioners practicing in underserved communities.

Impact on Other Entities

Description of the individuals, businesses, or other entities likely to be affected by the regulatory change. If no other entities will be affected, include a specific statement to that effect.	Licensed nurse practitioners, other than those licensed in the category of nurse midwife or nurse anesthetist, who have the equivalent of five years of full-time clinical practice with a patient care team physician.
Agency's best estimate of the number of such entities that will be affected. Please include an estimate of the number of small businesses affected. Small business means a business entity, including its affiliates, that: a) is independently owned and operated and; b) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million.	Based on the original year of licensure, there are approximately 4,000 persons who have held a license as a nurse practitioner for five years or more. However, it is unknown how many of that number have been actively engaged in full-time clinical practice. It is also unknown how many would constitute small businesses, but many LNPs work in large medical/hospital complexes. As of March 20, 2019, 151 LNPs have been authorized for autonomous practice, and there are 106 applications pending.
All projected costs for affected individuals, businesses, or other entities resulting from the regulatory change. Please be specific and include all costs including, but not limited to: a) projected reporting, recordkeeping, and other administrative costs required for compliance by small businesses; b) specify any costs related to the development of real estate for commercial or residential purposes that are a consequence of the regulatory change; c) fees; d) purchases of equipment or services; and e) time required to comply with the requirements.	There is a one-time application fee of $100 to obtain an autonomous practice designation.
Benefits the regulatory change is designed to produce.	For those nurse practitioners who want to establish an independent practice, the regulatory change provides a substantial benefit in being able to practice without a practice agreement or oversight by a physician.

Alternatives

Please describe any viable alternatives to the regulatory change that were considered, and the rationale used by the agency to select the least burdensome or intrusive alternative that meets the essential purpose of the regulatory change. Also, include discussion of less intrusive or less costly alternatives for small businesses, as defined in § 2.2-4007.1 of the Code of Virginia, of achieving the purpose of the regulatory change.

While there are no viable alternatives to the proposed regulatory action, the Boards intentionally sought input from interested parties prior to adoption of emergency regulations.

At its meeting on April 11, 2018, the Committee of the Joint Boards of Medicine and Nursing discussed the passage of HB793 and the timeline for promulgation of regulations. It was agreed that the following topics would require consideration in adoption of regulations to amend Chapters 30 (NP Licensure) and 40 (Prescriptive Authority):

- What is the equivalent of at least five years of full-time clinical experience?
- What does it mean to have routinely practiced in a practice area included within the category for which the NP was certified and licensed?
- What are requirements for an attestation for autonomous practice?
- What fee must be associated with submission of attestation and issuance of autonomous designation?
- What does "other evidence" demonstrating that the applicant has met the requirements could be accepted?
- How do the boards handle endorsement of experience in other states?

On May 17, 2018, the Committee of the Joint Boards of Nursing and Medicine and its Advisory Committee, serving as the Regulatory Advisory Panel (RAP), adopted recommended amendments to nurse practitioner regulations to implement the provisions of HB793.

A General Notice was posted on the Townhall and sent to persons on the Boards' public participation guidelines lists announcing that the Boards of Medicine and Nursing were seeking public comment on draft regulations to implement HB793 (Chapter 776 of 2018 General Assembly), legislation to authorize nurse practitioners who meet certain qualifications to practice without a practice agreement with a patient care team physician. Comment was posted on a public forum on Townhall and/or sent directly to the Boards or Agency Regulatory Coordinator.

All of the comment received and a summary of comment was provided to the Boards in their respective agenda packages. The Board of Nursing considered the draft regulations on July 17, 2018, and the Board of Medicine considered the draft regulations on August 3, 2018. Medicine accepted the draft adopted by Nursing with the exception of the number of hours equaling the equivalent of five years of full-time clinical practice (1,600 hours per year was adopted by Nursing; 1,800 was adopted by Medicine). At its meeting in September, the Board of Nursing concurred with the Board of Medicine on the emergency regulations.

Both boards unanimously adopted proposed regulations identical to emergency regulations currently in effect – Board of Medicine on February 21, 2019 and Board of Nursing on March 19, 2019.

Regulatory Flexibility Analysis

Pursuant to § 2.2-4007.1B of the Code of Virginia, please describe the agency's analysis of alternative regulatory methods, consistent with health, safety, environmental, and economic welfare, that will accomplish the objectives of applicable law while minimizing the adverse impact on small business. Alternative regulatory methods include, at a minimum: 1) establishing less stringent compliance or reporting requirements; 2) establishing less stringent schedules or deadlines for compliance or reporting requirements; 3) consolidation or simplification of compliance or reporting requirements; 4) establishing performance standards for small businesses to replace design or operational standards required in the proposed regulation; and 5) the exemption of small businesses from all or any part of the requirements contained in the regulatory change.

Promulgation of regulations is mandated by the Code as amended by Chapter 776 of the 2018 Acts of the Assembly.

Public Comment

Please summarize all comments received during the public comment period following the publication of the previous stage, and provide the agency response. Ensure to include all comments submitted: including those received on Town Hall, in a public hearing, or submitted directly to the agency or board. If no comment was received, enter a specific statement to that effect.

Public comment on the NOIRA to replace emergency regulations was requested from January 7, 2019 to February 6, 2019. There were no comments.

Public Participation

Please include a statement that in addition to any other comments on the regulatory change, the agency is seeking comments on the costs and benefits of the regulatory change and the impacts of the regulated community. Also, indicate whether a public hearing will be held to receive comments.

In addition to any other comments, the Boards of Nursing and Medicine are seeking comments on the costs and benefits of the proposal and the potential impacts of this regulatory proposal. Also, the agency/board is seeking information on impacts on small businesses as defined in § 2.2-4007.1 of the Code of Virginia. Information may include 1) projected reporting, recordkeeping and other administrative costs, 2) probable effect of the regulation on affected small businesses, and 3) description of less intrusive or costly alternative methods of achieving the purpose of the regulation.

Anyone wishing to submit written comments for the public comment file may do so by mail, email or fax to Elaine Yeatts at elaine.yeatts@dhp.virginia.gov or at 9960 Mayland Drive, Henrico, VA 23233 or by fax at (804) 527-4434.. Comments may also be submitted through the Public Forum

feature of the Virginia Regulatory Town Hall web site at: http://www.townhall.virginia.gov. Written comments must include the name and address of the commenter. In order to be considered, comments must be received by 11:59 pm on the last day of the public comment period.

A public hearing will be held following the publication of this stage and notice of the hearing will be posted on the Virginia Regulatory Town Hall website (**http://www.townhall.virginia.gov**) and on the Commonwealth Calendar website (https://www.virginia.gov/connect/commonwealth-calendar). Both oral and written comments may be submitted at that time.

Detail of Changes

Current section number	New section number, if applicable	Current requirement	Change, intent, rationale, and likely impact of new requirements
Chapter 30, section10		Defines words and terms used in Chapter 30	Adds a definition for "autonomous practice". *The enabling legislation did not define the term, so it was necessary to assign a term for practice without a practice agreement with a patient care team physician. Nurse practitioners contend that they do not practice "independently" but practice in collaboration with other health care providers, whether they have a practice agreement or not. Therefore, the term "independent practice" was not adopted. The definition also clarifies that autonomous practice must be in a category in which the nurse practitioner is licensed & certified.*
Chapter 30, section 20		Sets out the delegation of authority for licensure and renewal to the executive director of the Board of Nursing	Since nurse practitioners are jointly licensed and regulated, it is necessary to delegate the routine tasks of issuing and renewing licenses. Any questions of eligibility are referred to the Committee of the Joint Boards. The regulation was amended to include the granting of authorization for autonomous practice for qualified applicants in such delegation.
Chapter 30, section 50		Sets out fees for applicants and licensees	A fee of $100 is added for submission of attestation and issuance of autonomous practice authorization. The Code requires submission of a fee to accompany an attestation for autonomous practice (subsection I of 54.1-2957). As a non-general fund agency, the boards are required to cover the expense for this activity with a related fee. While routine application for autonomous practice are delegated to Nursing staff, there will be IT costs and staff time reviewing applications, entering data, and issuing an authorization. Non-routine

			applications will require a higher level of review and may necessitate conveying an informal conference to review an attestation and accompanying documentation. Additionally, there is no renewal fee for autonomous practice authorization, to the initial fee must cover any costs related to potential investigation and adjudication of complaints. In another action, prescriptive authority regulations are being amended to reduce the fee for initial issuance of prescriptive authority from $75 to $35 and to eliminate the biennial renewal fee of $35. Therefore, a one-time cost for autonomous practice authorization will be offset by a reduced cost for prescriptive authority.
Chapter 30, section 85		Sets out the qualifications for licensure by endorsement	Amendments to 54.1-2957 provide: *A nurse practitioner to whom a license is issued by endorsement may practice without a practice agreement with a patient care team physician pursuant to subsection I if such application provides an attestation to the Boards that the applicant has completed the equivalent of at least five years of full-time clinical experience, as determined by the Boards, in accordance with the laws of the state in which the nurse practitioner was licensed.* Therefore, section 85 is amended to specify that an applicant for endorsement must follow the requirements for proof of the equivalent of five years of full-time clinical practice as set forth in section 86.
	Chapter 30, section 86	Sets out the qualifications for autonomous practice	Subsection A sets out the statutory requirement of the equivalent of five years of full-time clinical experience. The definition of clinical experience is identical to the definition in subsection A of 54.1-2957. The boards did have discretion in establishing the equivalency for five years of full-time practice. Full-time is often equated to 2,000 hours of work per year. However, in many hospital systems, nurse practitioners who work a 36-hour per week schedule are considered to be “full-time.” Therefore, the boards adopted 1,800 hours per year or a total of 9,000 hours to be the equivalent of full-time. Subsection B sets out the requirement for submission of a fee and the content for an attestation consistent with the language in the Code. As specified in 54.1-2957, the nurse practitioner must submit: *an attestation from the patient care team physician stating (i) that the patient care team physician has served as a patient care team physician on a patient care team with the nurse practitioner pursuant to a practice agreement meeting the requirements of this section and §*

			54.1-2957.01; (ii) that while a party to such practice agreement, the patient care team physician routinely practiced with a patient population and in a practice area included within the category for which the nurse practitioner was certified and licensed; and (iii) the period of time for which the patient care team physician practiced with the nurse practitioner under such a practice agreement. Subsection C allows the nurse practitioner to submit more than one attestation to prove the equivalent of five years of practice if he/she has worked with more than one patient care team physician. Subsection D specifies that if the nurse practitioner is licensed and certified in more than one category (see section 70 of Chapter 30), a separate attestation and fee must be submitted for each. The hours of practice related to that category and patient population may be counted towards a second attestation. For example, if an NP licensed and certified as an Adult NP has been working with an adult population with substance abuse/mental health issues and wants to also become certified as a Psychiatric NP, he/she could count the hours spent working in that category with that patient population for the second area of autonomous practice. Subsection E sets out the circumstances and process by which an NP who is unable to obtain an attestation is able to submit other evidence of five years of full-time clinical experience (subsection I of 54.1-2957). The burden is on the NP to provide sufficient evidence for his/her inability to obtain an attestation of for the verification of practice. Subsection F specifies that an applicant for licensure by endorsement may submit evidence of the equivalent of five years of full-time clinical experience that was in accordance with the laws of the state in which he/she previously practiced. For example, if the NP practiced in a state in which autonomous practice was allowed, he/she would need to provide satisfactory evidence of such practice under the laws of that state. Subsection G sets out the statutory requirements for autonomous practice as specified in subsection I of 54.1-2957:

			A nurse practitioner authorized to practice without a practice agreement pursuant to this subsection shall (a) only practice within the scope of his clinical and professional training and limits of his knowledge and experience and consistent with the applicable standards of care, (b) consult and collaborate with other health care providers based on the clinical conditions of the patient to whom health care is provided, and (c) establish a plan for referral of complex medical cases and emergencies to physicians or other appropriate health care providers.
Chapter 30, section 110		Sets out requirements for reinstatement of licensure	A nurse practitioner whose license has been lapsed for more than two years must provide the initial authorization fee and attestation in order to have autonomous practice authorization with such reinstatement.
Chapter 30, section 120		Sets out the requirements for practice of licensure nurse practitioners, other than nurse anesthetists or nurse midwives	Amendments are added to reference practice in accordance with section 86 if authorized for autonomous practice.
Chapter 40 Section 90		Sets out requirements for a practice agreement for a nurse practitioner with prescriptive authority	An amendment is added to subsection E to provide an exception to the requirement for a practice agreement for a nurse practitioner who has met the qualifications for autonomous practice as set forth in 18VAC90-30-86.